UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

---------- X

JUSTIN SHERWOOD,

Plaintiff,

-against-

THE CITY OF NEW YORK, ET AL.,

Defendants.

---------- X

NYC DEFENDANTS' FIRST SET OF INTERROGATORIES AND REQUEST FOR PRODUCTION OF DOCUMENTS

22-cv-7505 (BMC)

Pursuant to Rules 26, 33, and 34 of the Federal Rules of Civil Procedure and Local Civil Rule 26.3, defendants City and Officer Tiagom Reis ("NYC Defendants") hereby request that plaintiff serve upon the undersigned sworn written answers to each of the interrogatories set forth below and produce the documents requested below at the offices of HON. SYLVIA O. HINDS-RADIX, Corporation Counsel of the City of New York, 100 Church Street, New York, New York 10007, within 30 days after service hereof.

INSTRUCTIONS AND DEFINITIONS

1. NYC Defendants hereby incorporate the Uniform Definitions in Discovery Requests contained in Local Civil Rule 26.3.

2. The term "Incident" means the facts and circumstances underlying the claims in this action, including without limitation, the incident forming the basis of this action, and any related arrest, confinement and/or prosecution.

3. If the answer to all or any part of an interrogatory is not presently known or available, include a statement to that effect and furnish any information currently known or available, and a description of the source of information that was once known or available that

could have been used to respond to the interrogatory.

4. If any document responsive to these interrogatories or documents requests has been lost, destroyed or is otherwise unavailable, identify such document, and, in addition, identify the last known custodian, and provide the date the document was lost, destroyed or otherwise became unavailable.

5. If a claim of privilege is asserted with respect to any information called for by an interrogatory is, or any documents or portions thereof are, withheld by reason of a claim of privilege, provide a privilege log containing the information required by Local Rule 26.2.

6. These interrogatories and document requests are continuing. If at any time after service of responses to these requests, plaintiff learns that in some material respect the responses are incomplete or incorrect, plaintiff should, within seven days, and in no event later than the close of discovery, provide NYC Defendants with such information or documents by amended or supplemental responses.

INTERROGATORIES

1. Identify all persons who: (a) witnessed, were present at, or have knowledge of the Incident, and (b) witnessed or have knowledge of plaintiff's emotional injuries or damages arising from, or caused or exacerbated by, the Incident. If plaintiff is unable to identify any person within the meaning of Local Civil Rule 26.3, describe each person's physical appearance.

2. Identify any person and/or entity, including, but not limited to the media, Civilian Complaint Review Board, NYPD's Office of the Inspector General ("OIG") or Internal Affairs Bureau, District Attorney, Attorney General, U.S. Attorneys' Office or other law enforcement agency with whom plaintiff, or anyone on plaintiff's behalf, communicated concerning the Incident.

3. Identify all documents and communications concerning (a) the Incident, and/or (b) any emotional injuries, and damages that plaintiff claims arose from, or were caused or exacerbated by, the Incident.

4. Identify all photographs, video or audio recordings, or their electronic equivalent (images and/or files on any electronic storage device such as cell phones, PDA's, computers) concerning (a) the Incident, and/or (b) any injuries and/or damages arising from, or caused or exacerbated by, the Incident.

5. Describe all emotional injuries, ailments, disabilities and pains that plaintiff claims were caused or exacerbated by the Incident, and any condition that is a consequence of each such injury, ailment, disability and pain.

6. Identify any healthcare providers plaintiff saw or received treatment from for injuries identified in paragraph 6 above. If plaintiff did not see or receive treatment from any healthcare provider for any injuries identified in paragraph 6 above so state in writing.

7. If plaintiff claims that any injury or condition was exacerbated by the Incident, describe that injury or condition, and identify all healthcare providers who saw or treated plaintiff for each such pre-existing injury or condition in the past 10 years.

8. Provide a computation of each category of economic damages that plaintiff claims were caused, in whole or in part, by the Incident, including without limitation lost income, out-of-pocket expenses, property damage, attorneys' fees, medical or pharmacy expenses, court fees, bail, commissary expenses, and/or travel expenses, and identify all documents upon which plaintiff's computations are based.

9. If plaintiff is making a claim for lost income, identify all plaintiff's employers for the past 10 years, including the dates of employment.

10. State whether plaintiff has been arrested on any occasion, and, if so, for each such arrest, provide the State, county or jurisdiction of the arrest, the date of the arrest and the arrest charges.

11. State whether plaintiff has been a defendant in a criminal proceeding (felony, misdemeanor or violation) on any occasion, and if so, for each criminal proceeding, provide the State, county, court, case or indictment number, date the prosecution was initiated, and the disposition.

12. State whether plaintiff has been a party to any lawsuit or administrative proceeding, and, if so, provide the State, court or administrative body, caption, case, docket or index number, the date the lawsuit or proceeding was initiated, and the disposition.

13. Identify all persons/entities who provided healthcare to plaintiff within the past ten years.

14. Identify all persons/entities who provided healthcare insurance coverage to plaintiff within the past ten years.

15. State whether plaintiff has applied for or has received any government benefits, including without limitation, worker's compensation, food stamps, social security disability, Medicare and/or Medicaid, within the past 10 years. If so, identify each person/entity who provided benefits, or to whom plaintiff made an application for benefits, and all applicable claim numbers.

16. State whether plaintiff made an application or claim for any disability or no-fault insurance coverage within the past 10 years. If so, for each application or claim identify the person/entity to whom plaintiff applied for coverage and all claim numbers.

17. Identify all instances prior and subsequent to the Incident, in which plaintiff has made 311 complaints, including the dates, times, subjects of the complaint, and locations.

DOCUMENT REQUESTS

1. Produce all documents identified in your responses to the Interrogatories.

2. Produce all documents and communications concerning the Incident.

3. Produce all documents concerning any injuries or damages that plaintiff claims were caused or exacerbated by the Incident.

4. Produce all documents concerning economic damages or losses that plaintiff claims were caused by the Incident.

5. Produce all documents and communications relating to the defense of any criminal prosecution, appeal or petitions concerning the Incident, including without limitation, the files and documents in the possession of your criminal defense attorneys, appellate attorneys, C.P.L. 440, habeas, or probation or parole attorneys who were in anyway involved in any aspect of your prosecution or incarceration.

6. Produce all documents concerning any complaints or statements made by plaintiff or anyone on plaintiff's behalf, or communications to any person/entity, including without limitation the media, U.S. Department of Justice, U.S. Attorneys' Office, District Attorney's Office, N.Y.S. Attorney General, CCRB, or NYPD's OIG or IAB, or any law enforcement agency, concerning the Incident.

7. Produce all photographs, video or audio recordings, or their electronic equivalent (images and/or files on any electronic storage device such as cell phones, PDA's, computers, CD-ROMs or DVD's), concerning (a) the Incident, and/or (b) any injuries and/or damages arising from, or caused or exacerbated by, the Incident. Defendant requests exact duplicates of all images and/or files on any electronic storage device, with all metadata, including without limitation, all date, time and location stamps.

8. Produce all documents concerning the individual defendants or any involved City employees or officers, including, without limitation, documents from the media, internet searches, internet-based social network sites, any on-line databases including the NYC disciplinary databases, NYCLU database, LAS Cop Accountability Project, CAPstat.nyc, other claims or lawsuits, and/or criminal proceedings.

9. If plaintiff claims that any pre-existing emotional condition was exacerbated by the Incident, produce all documents concerning the pre-existing injury or condition that was exacerbated by the Incident.

10. Produce a completed medical release for plaintiff's healthcare records and healthcare insurance coverage records for each person/entity who provided healthcare for any emotional injuries that plaintiff claims arose from, or were caused or exacerbated by, the Incident (this includes without limitation releases for any EMS service, Central Booking pre-arraignment medical screening) and Correctional Health Services.[1] Copies of the standard NYS HIPAA release and NYCHHC HIPAA release are attached. If plaintiff received healthcare for any emotional injury from any healthcare provider (e.g., psychiatrist, psychologist, therapist or social worker), for each such person also produce a separate, signed release for psychotherapy notes. A blank psychotherapy note release is attached.

11. If plaintiff claims that any pre-existing condition was exacerbated by the Incident, produce completed medical releases for plaintiff's healthcare records and healthcare

[1] Produce a separate medical release for each healthcare provider and/or healthcare insurance coverage provider The medical releases should be fully executed by plaintiff in the format acceptable to the healthcare provider or healthcare insurance coverage provider to whom it is addressed, and should be initialed so as to permit defense counsel to speak to the healthcare provider. Authorizations for Correctional Health Services records must be addressed to NYC Health & Hospital, CHS Medical Records Unit, 55 Water Street 18th Floor, New York, New York 10041.

insurance coverage records for plaintiff's records concerning the treatment of any such pre-existing condition in the past 10 years. If plaintiff claims that any pre-existing emotional condition was exacerbated by the Incident, for each health care provider who provided healthcare for that condition, also produce a separate release for psychotherapy notes.

12. Produce completed medical releases for the release of plaintiff's healthcare records for all persons/entities who provided healthcare and health insurance coverage to plaintiff in the past 10 years. Provide separate medical releases for each such person/entity. If plaintiff received healthcare for any emotional injury from any person (for example, psychiatrist, psychologist, therapist or social worker), also produce a signed release for psychotherapy notes for each such person/entity.

13. If the plaintiff is claiming loss of earnings, income or earning capacity, produce all documents upon which the loss is computed, including without limitation, tax records (federal and state), employment records, bookkeeping or accounting records, and time and attendance records since the Incident, and similar records for 10 years before the Incident.

14. If plaintiff is claiming any loss of earnings, loss of earning capacity or lost income, produce a signed release permitting defendants to obtain plaintiff's employment records for each of plaintiff's employers for the past 5 years. A blank employment record release form is attached. Produce a separate release for each employer.

15. For each separate period of time when plaintiff was unemployed during the past 5 years, produce a signed release permitting defendant to obtain plaintiff's unemployment records. A blank unemployment insurance release form is attached.

16. If the plaintiff is claiming loss of earnings, income or earning capacity, produce a signed release for plaintiff's federal tax records since the Incident and for 5 years before the incident. A blank IRS Form 4506 is attached.

17. If plaintiff is or was a student on the date of the Incident, produce a signed release for the release of plaintiff's education records including, without limitation, attendance records, transcripts or grades, counseling records and disciplinary records for the past 5 years. The blank education release form is attached. Produce a separate release for each school.

18. For each claim with any insurance carrier (disability or no-fault) for emotional injuries within the past ten years, complete and produce a signed release for plaintiff's records. A blank form for the release of insurance records is attached.

19. Produce all subpoenas served on any person/entity concerning the Incident, this litigation or plaintiff's injuries or damages that arose from, or were caused or exacerbated by, the Incident, and all documents received in response to any subpoena.

20. Produce all FOIA/FOIL requests served on any person/entity concerning the Incident, and all documents received in response to any such requests.

21. Produce a signed blanket release under Criminal Procedure Law §§ 160.50 and 160.55 permitting defendants to obtain plaintiff's criminal records, and/or, if applicable, a signed blanket release under the Family Court Act § 375.1 permitting defendants to obtain plaintiff's Family Court records. The blanket release forms are attached.[2]

22. Produce (a) all expert disclosures required pursuant to Federal Rule 26(a)(2), and (b) all communications that (i) concern compensation for the expert's study or testimony, (ii) identify facts or data that the party's attorney provided and that the expert considered in forming the opinions to be expressed, and (iii) identify assumptions that the party's attorney provided and that the expert relied on in forming the opinions to be expressed.

[2] This authorization differs from the authorization that may have been provided at the commencement of this litigation in that it is not limited to just documents pertaining to the arrest and/or prosecution that is the subject of this litigation.

23. Produce all documents concerning any claims against the City or its agents, servants or employees, concerning the Incident, including without limitation all notices of claim, communications with the City Comptroller or its agents, 50-H hearing transcripts and errata sheets relating thereto.

24. Produce all retainer agreements, referral agreements, time and expense records and legal bills concerning the Incident or all criminal, administrative and civil proceedings or prosecutions concerning the Incident, including this litigation.

25. Produce all documents concerning any legal or litigation financing or funding from any person for any claims or lawsuits concerning the Incident.

DATED: New York, New York
February 28, 2023

HON. SYLVIA O. HINDS-RADIX
Corporation Counsel
of the City of New York
Attorney for Defendants City and Reis
100 Church Street, Room 3-159
New York, New York 10007
(212) 356-3539
jschemit@law.nyc.gov

By: _____/s/_____
John Schemitsch

JUSTIN SHERWOOD v. CITY OF NEW YORK, ET AL., No. 22-cv-7505

RELEASE FOR PSYCHOTHERAPY NOTES

TO: _____ [Health Care Provider]
_____ [Address]
_____ [City, State, Zip]

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations, 45 CFR § 164.508, YOU ARE HEREBY AUTHORIZED AND DIRECTED to furnish to HON. SYLVIA O. HINDS-RADIX, Corporation Counsel of the City of New York, or to her authorized representative, a certified copy of all psychotherapy notes of Justin Sherwood (Date of Birth: _____; SS #: _____) who was examined or treated in your hospital/office/clinic or by you on or about _____.

The reason for this release of information is (a) at the request of individual, or (b) _____. This authorization will terminate upon the resolution of my lawsuit. The aforementioned expiration date has not passed as this matter is ongoing.

I have the right to revoke this authorization in writing by providing a signed, written notice of revocation to the health care provider listed above and to HON. SYLVIA O. HINDS-RADIX, except to the extent that the provider listed above has taken action in reliance on this authorization. Medical providers may not condition treatment or payment on whether the above-listed patient executes this authorization. The information disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA).

_____
Justin Sherwood

STATE OF NEW YORK, COUNTY OF _____)) SS.:

On the _____ day of _____, 2023, before me personally came and appeared Justin Sherwood, to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he/she executed the same.

_____
Notary Public

JUSTIN SHERWOOD v. NEW YORK CITY, ET AL., No. # 22-cv-7505

BLANKET DESIGNATION OF AGENT FOR ACCESS TO RECORDS SEALED PURSUANT TO NYCPL §§ 160.50 AND 160.55

I, Justin Sherwood, Date of Birth _____; SS #: _____, NYSID # _____ pursuant to CPL §§ 160.50 and 160.55, hereby designate HON. SYLVIA O. HINDS-RADIX, Corporation Counsel of the City of New York, or her authorized representative, as my agent to whom all records of any of my arrests may be made available.

I understand that until now the aforesaid records have been sealed pursuant to CPL §§ 160.50 and 160.55, which permits those records to be made available only (1) to persons designated by me, or (2) to certain other parties specifically designated in that statute.

I further understand that the person designated by me above as a person to whom the records may be made available is not bound by the statutory sealing requirements of CPL § 160.50 and 160.55.

The records to be made available to the person designated above comprise all records and papers relating to any and all of my arrests on file with any court, police agency, prosecutor's office or state or local agency that were ordered to be sealed under the provisions of CPL §§ 160.50 and 160.55.

_____
Justin Sherwood

STATE OF NEW YORK)
: SS.:
COUNTY OF)

On this _____ day of _____, 2023, before me personally came Justin Sherwood to me known and known to me to be the individual described in and who executed the foregoing instrument, and he acknowledged to me that he executed the same.

_____
NOTARY PUBLIC

JUSTIN SHERWOOD v. NEW YORK CITY, ET AL., No. # 22-cv-7505

BLANKET DESIGNATION OF AGENT FOR ACCESS TO SEALED RECORDS PURSUANT TO FAMILY COURT ACT SECTION 375.1

I, _____, Date of Birth _____, pursuant to Family Court Act Section 375.1 hereby designate HON. SYLVIA O. HINDS-RADIX, Corporation Counsel of the City of New York, or her authorized representative, as my agent to whom records of any of my juvenile delinquency proceedings be made available.

I understand that until now the aforesaid records have been sealed pursuant to Family Court Act Section 375.1 and that Family Court Act Section 375.1(3) permits those records to be made available only to me or persons designated by me, or to certain other parties designated in the Family Court Act.

I authorize the Family Court Division to provide the aforementioned records to the Corporation Counsel of the City of New York, or his authorized representative.

_____
Signature of Juvenile

_____
Signature of Parent/Guardian

STATE OF NEW YORK)
: SS
COUNTY OF _____)

On this ____ day of _____, 20___, before me personally came _____, to me known and known to me to be the individual described in and who executed the foregoing instrument, and (s)he acknowledged to me that (s)he executed the same.

_____
NOTARY PUBLIC

STATE OF NEW YORK)
: SS
COUNTY OF _____)

On this ____ day of _____, 2023, before me personally came _____, to me known and known to me to be the individual described in and who executed the foregoing instrument, and (s)he acknowledged to me that (s)he executed the same.

_____
NOTARY PUBLIC

JUSTIN SHERWOOD v. NEW YORK CITY, ET AL., No. # 22-cv-7505

RELEASE FOR
EMPLOYMENT RECORDS

TO: _____
NAME AND ADDRESS OF EMPLOYER

YOU ARE HEREBY AUTHORIZED to furnish to HON. SYLVIA O. HINDS-RADIX, Corporation Counsel of the City of New York, or to her authorized representative, a **CERTIFIED COPY** of the entire employment record, including but not limited to the application, attendance records, disciplinary records, performance evaluations, workers' compensation records, medical records/nurses records, and/or any doctors notes, and psychiatric/psychological records of Justin Sherwood (Date of Birth _____; SS #: _____), employed by you from _____ until _____.

Dated: _____, New York
_____

_____
Justin Sherwood

STATE OF NEW YORK)
: SS:
COUNTY OF _____)

On the _____ day of _____, 2023, before me personally came and appeared Justin Sherwood, to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he executed the same.

_____
NOTARY PUBLIC

JUSTIN SHERWOOD v. NEW YORK CITY, ET AL., No. # 22-cv-7505

RELEASE FOR
SCHOOL RECORDS

TO: _____
NAME OF SCHOOL

YOU ARE HEREBY AUTHORIZED to furnish to HON. SYLVIA O. HINDS-RADIX, Corporation Counsel of the City of New York, attorney for the defendants in the above-captioned case, or her authorized representative, a **CERTIFIED COPY** of the entire school record of Justin Sherwood (Date of Birth _____; SS #: _____).

The entire school record, includes but is not limited to report cards, transcripts, test results and scores, attendance records, evaluations, disciplinary records, Chapter 53 student screening, psychological/psychiatric records, parent/teacher conference notes, physical exam records, medical/nurse records, and/or any doctors notes related to such person.

Dated: New York, New York
_____, 2023

_____
Justin Sherwood

STATE OF NEW YORK)
: SS:
COUNTY OF _____)

On the _____ day of _____, 2023, before me personally came and appeared, Justin Sherwood to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that she executed the same.

_____
NOTARY PUBLIC

JUSTIN SHERWOOD v. NEW YORK CITY, ET AL., No. # 22-cv-7505

RELEASE
FOR INSURANCE
CARRIER RECORDS

TO: _____
NAME AND ADDRESS OF INSURANCE CARRIER

YOU ARE HEREBY AUTHORIZED to furnish to HON. SYLVIA O. HINDS-RADIX, Corporation Counsel of the City of New York, or to her authorized representative, a **CERTIFIED COPY** of the entire file of Justin Sherwood (Date of Birth _____; SS #: _____), who received benefits from your insurance company.

The insurance carrier file authorized for release includes, but is not limited to, any and all applications, description of injuries, determinations, correspondence, payments or credits and all documents relating to such person's claim for insurance benefits or no-fault file (relating to injuries sustained on or about _____) .

Dated: _____, New York
_____

_____
Justin Sherwood

STATE OF NEW YORK)
: SS:
COUNTY OF _____)

On the _____ day of _____, 2023, before me personally came and appeared Justin Sherwood, to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he executed the same.

_____
NOTARY PUBLIC

AUTHORIZATION FOR RELEASE OF UNEMPLOYMENT INSURANCE RECORDS

I,_____, SS#_____,

reside at _____

_____, and hereby authorize the New York State

Department of Labor ("Department") to release unemployment insurance records for the

period of _____ maintained by the Department under the above

stated social security number.

These records may be released to_____

whose address is _____

_____.

This information is sought for the purpose of _____

_____

and will be used solely for this purpose.

_____

Sworn to before me this

_____ day of__, 20_

_____

Notary Public

Medicare

Beneficiary Services:1-800-MEDICARE (1-800-633-4227)
TTY/ TDD:1-877-486-2048

This form is used to advise Medicare of the person or persons you have chosen to have access to your personal health information.

For faster processing, you may complete your Authorization form online by logging into www.MyMedicare.gov with valid credentials where Authorized Representatives can be added or updated under 'My Accounts'.

Where to Return Your Completed Authorization Forms:
After you complete and sign the authorization form, return it to the address below:

Medicare BCC, Written Authorization Dept.
PO Box 1270
Lawrence, KS 66044

For New York Medicare Beneficiaries ONLY

The New York State Public Health Law protects information that reasonably could identify someone as having HIV symptoms or infection, and information regarding a person's contacts. Because of New York's laws protecting the privacy of information related to alcohol and drug abuse, mental health treatment, and HIV, there are special instructions for how you, as a New York resident, should completethis form.

- For question 2A, check the box for *Limited Information*, even if you want to authorize Medicare to release any and all of your personal health information.

- **Then proceed to question 2B.** You may also check any of the remaining boxes and include any additional limitations in the space provided. For example, you could write "payment information".

Medicare BCC, Written Authorization Dept.
PO Box 1270
Lawrence, KS 66044

Instructions for Completing Section 2C of the Authorization Form:
Please select one of the following options.

- **Option 1** To **include** all information, check the box: "All information, including information about alcohol and drug abuse, mental health treatment, and HIV". Proceed with the rest of the form.

- **Option 2** To **exclude** the information listed above, check the box "Exclude information about alcohol and drug abuse, mental health treatment, and HIV". Then proceed with the rest of the form.

If you have any questions or need additional assistance, please feel free to call us at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Sincerely,

1-800-MEDICARE
Customer Service Representative

Encl.

Information to Help You Fill Out the "1-800-MEDICARE Authorization to Disclose Personal Health Information" Form

By law, Medicare must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that isn't set out in the privacy notice contained in the Medicare & You handbook. You may take back ("revoke") your written permission at any time, exceptif Medicare has already acted based on your permission.

If you want 1-800-MEDICARE to give your personal health information to someone other than you,you need to let Medicare know in writing.

If you are requesting personal health information for a deceased beneficiary, please include a copy of the legal documentation which indicates your authority to make a request for information. (For example: Executor/Executrix papers, next of kin attested by court documents with a court stamp and a judge's signature, a Letter of Testamentary or Administration with a court stamp and judge's signature, or personal representative papers with a court stamp and judge's signature.) Also, please explain your relationship to the beneficiary.

Please use this step by step instruction sheet when completing your "1-800-MEDICARE Authorization to Disclose Personal Health Information" Form. Be sure to complete all sections of the form to ensure timely processing.

1. Print the name of the person with Medicare.

Print the Medicare number exactly as it is shown on the red, white, and blue Medicare card,including any letters.

Print the birthday in month, day, and year (mm/dd/yyyy) of the person with Medicare.

2. This section tells Medicare what personal health information to give out. Please check a box in 2A to indicate how much information Medicare can disclose. If you only want Medicare to give out limited information (for example, Medicare eligibility), also check the box(es) in 2B that apply to the type of information you want Medicare to give out. Box 2C must be completed by **New York Residents**.

3. This section tells Medicare when to start and/or when to stop giving out your personal health information. Check the box that applies and fill in dates, if necessary.

4. This section tells Medicare the reason for disclosure.

5. Medicare will give your personal health information to the person(s) or organization(s) you fill in here. You may fill in more than one person or organization.

If you designate an organization, you must also identify one or more individuals in thatorganization to whom Medicare may disclose your personal health information.

6. The person with Medicare or personal representative must sign their name, fill in the date, and provide the phone number and address of the person with Medicare.

If you are a personal representative of the person with Medicare, check the box, provide your address and phone number, and attach a copy of the paperwork that shows you can act for that person (for example, Power of Attorney).

7. Send your completed, signed authorization to Medicare at the address shown here on your authorization form.

8. If you change your mind and don't want Medicare to give out your personal health information, write to the address shown under number six on the authorization form and tell Medicare. Your letter will revoke your authorization and Medicare will no longer give out your personal health information (except for the personal health information Medicare has already given out based on your permission).

You should make a copy of your signed authorization for your records before mailing it to Medicare.

1-800-MEDICARE Authorization to Disclose Personal Health Information

Use this form if you want 1-800-MEDICARE to give your personal health information to someoneother than you.

1. Print Name (First and last name of the person with Medicare)	**Medicare Number** (Exactly as shown on the Medicare Card)	**Date of Birth** (mm/dd/yyyy)

2. Medicare will only disclose the personal health information you want disclosed.

2A: Check only <u>one</u> box below to tell Medicare the specific personal health information youwant disclosed:

- ☐ Limited Information (go to question 2b)
- ☐ Any Information (go to question 3)

2B: Complete <u>only</u> if you selected "limited information". Check all that apply:

- ☐ Information about your Medicare eligibility
- ☐ Information about your Medicare claims
- ☐ Information about plan enrollment (e.g. drug or MA Plan)
- ☐ Information about premium payments
- ☐ Other Specific Information (please write below; for example, payment information)

_____

_____

2C: NY Residents Only, this section must be completed.
Please select one of the following options: (Please check only one box.)

- ☐ Include all information. This includes information about alcohol and drug abuse, mental health treatment, and HIV.

OR

- ☐ Exclude information about alcohol and drug abuse, mental health treatment, and HIV.

3. **Check only one box below indicating how long Medicare can use this authorization to disclose your personal health information** (subject to applicable law—for example, your State may limit how long Medicare may give out your personal health information):

☐ Disclose my personal health information indefinitely

☐ Disclose my personal health information for a specified period only

beginning:_____(mm/dd/yyyy) and ending: _____(mm/dd/yyyy)

4. **Fill in the reason for the disclosure (you may write "at my request"):**

_____

_____

5. **Fill in the name and address of the person or organization to whom you want Medicare to disclose your personal health information. Please provide the specific name of the person for any organization you list below. If you would like to authorize any additional individuals or organizations, please add those to the back of this form.**

Name _____

Address _____

Name _____

Address _____

Note: You have the right to take back ("revoke") your authorization at any time, in writing, except to the extent that Medicare has already acted based on your permission. To revoke authorization, send a written request to the address noted below. Your authorization or refusal to authorize disclosure of your personal health information will have no effect on your enrollment, eligibility for benefits, or the amount Medicare pays for the health services you receive.

6.

I authorize 1-800-MEDICARE to disclose my personal health information listed above to the person(s) or organization(s) I have named on this form. I understand that my personal health information may be re-disclosed by the person(s) or organization(s) and

_____ _____ _____

Signature Telephone Number Date

Print the address of the person with Medicare (Street Address, City, State, and ZIP)

☐ Check here if you are signing as a personal representative and complete below.
Please attach the appropriate documentation (for example, Power of Attorney). This only applies if someone other than the person with Medicare signed above.

Print the Personal Representative's Address (Street Address, City, State, and ZIP)

Telephone Number of Personal Representative: _____

Personal Representative's Relationship to the Beneficiary: _____

7. **Send the completed, signed authorization to**:

Medicare BCC, Written Authorization Dept.
PO Box 1270
Lawrence, KS 66044

Print Form

Note: You have the right to take back ("revoke") your authorization at any time, in writing, except to the extent that Medicare has already acted based on your permission. If you would like to revoke authorization, send a written request to the address noted above.

Your authorization or refusal to authorize disclosure of your personal health information will have no effect on your enrollment, eligibility for benefits, or the amount Medicare pays for the health servicesyou receive.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0930. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

NYCHHC HIPAA Authorization to Disclose Health Information

ALL FIELDS MUST BE COMPLETED

THIS FORM MAY NOT BE USED FOR RESEARCH OR MARKETING, FUNDRAISING OR PUBLIC RELATIONS AUTHORIZATIONS

PATIENT NAME/ADDRESS	DATE OF BIRTH	PATIENT SSN
	MEDICAL RECORD NUMBER	TELEPHONE NUMBER

NAME OF HEALTH PROVIDER TO RELEASE INFORMATION	SPECIFIC INFORMATION TO BE RELEASED: Information Requested_____ Treatment Dates from_____to_____
NAME & ADDRESS OF PERSON OR ENTITY TO WHOM INFO. WILL BE SENT	INFORMATION TO BE RELEASED (If the box is checked, you are authorizing the release of that type of information). **Please note: unless all of the boxes are checked, we may be unable to process your request.** ☐ Alcohol and/or Substance Abuse Program Information ☐ Mental Health Information ☐ Genetic Testing Information ☐ HIV/AIDS-related Information
REASON FOR RELEASE OF INFORMATION ☐ Legal Matter ☐ Individual's Request ☐ Other (please specify):_____	WHEN WILL THIS AUTHORIZATION EXPIRE? (Please check one) ☐ Event:_____ ☐ On this date:_____

I, or my authorized representative, authorize the use or disclosure of my medical and/or billing information as I have described on this form.

I understand that my medical and/or billing information could be re-disclosed and no longer protected by federal health information privacy regulations if the recipient(s) described on this form are not required by law to protect the privacy of the information.

I understand that if my medical and/or billing records contain information relating to **ALCOHOL** or **SUBSTANCE ABUSE**, **GENETIC TESTING**, **MENTAL HEALTH**, and/or **CONFIDENTIAL HIV/AIDS RELATED INFORMATION**, this information will not be released to the person(s) I have indicated unless I check the box(es) for this information on this form.

I understand that if I am authorizing the use or disclosure of HIV/AIDS-related information, the recipient(s) is prohibited from using or re-disclosing any HIV/AIDS-related information without my authorization, unless permitted to do so under federal or state law. I also understand that I have a right to request a list of people who may receive or use my HIV/AIDS-related information without authorization. If I experience discrimination because of the use or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 212.480.2493 or the New York City Commission of Human Rights at 212.306.7450. These agencies are responsible for protecting my rights.

I understand that I have a right to refuse to sign this authorization and that my health care, the payment for my health care, and my health care benefits will not be affected if I do not sign this form. I also understand that if I refuse to sign this authorization, NYCHHC cannot honor my request to disclose my medical and/or billing information.

I understand that I have a right to request to inspect and/or receive a copy of the information described on this authorization form by completing a Request for Access Form. I also understand that I have a right to receive a copy of this form after I have signed it.

I understand that if I have signed this authorization form to use or disclose my medical and/or billing information, I have the right to revoke it at any time, except to the extent that NYCHHC has already taken action based on my authorization or that the authorization was obtained as a condition for obtaining insurance coverage.

To revoke this authorization, please contact the facility Health Information Management department processing this request.

I have read this form and all of my questions have been answered. By signing below, I acknowledge that I have read and accept all of the above.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE	IF NOT PATIENT, PRINT NAME & CONTACT INFORMATION OF PERSONAL REPRESENTATIVE SIGNING FORM
DATE	DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY TO ACT ON BEHALF OF PATIENT

If HHC has requested this authorization, the patient or his/her Personal Representative must be provided a copy of this form after it has been signed.

HHC USE ONLY	
Date Received:	Initials of HIM employee processing request:

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health)

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9. (a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: *(Indicate by Initialing)*

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here_____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a government agency, listed here:

_____

(Attorney/ Firm Name or Government Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. **Authority** to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child, you may complete this form to release only the minor's non-medical records. We may charge a fee for providing information unrelated to the administration of a program under the Social Security Act.

NOTE: Do not use this form to:

- Request the release of medical records on behalf of a minor child. Instead , visit your local Social Security office or call our toll free number, 1-800-772-1213 (TTY-1-800-325-0778), or
- Request detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "any and all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form. We may charge a fee to release information for non-program purposes.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the personto whom the requested information pertains.
- Fill in the name and address of the person or organization where you want us to send the requested information.
- Specify the reason you want us to release the information.
- Check the box next to the type(s) of information you want us to release including the date ranges, where applicable.
- For non-medical information, you, the parent or the legal guardian acting on behalf of a minor child or legally incompetent adult,must sign and date this form and provide a daytime phone number.
- If you are not the individual to whom the requested information pertains, state your relationship to that person. We may requireproof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. We will use the information you provide to respond to your request for access to the records we maintain about you or to process your request to release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent. We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, the Privacy Act (5 U.S.C. § 552a(b)) permits us to disclose the information you provide on thisform in accordance with approved routine uses, which include but are not limited to the following:

1. To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and or coverage;
2. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;
3. To comply with Federal laws requiring the disclosure of the information from our records; and,
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We use information from these matching programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or overpayments under these programs. Additional information regarding this form, routine uses of information, and other Social Security programs is available on our Internet website, www.socialsecurity.gov, or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website** at www.socialsecurity.gov. **Offices are also listed under U.S. Government agenciesin your telephone directory or you may call 1-800-772-1213 (TYY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

Consent for Release of Information
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*Signifies a required field. **Please complete these fields in case we need to contact you about the consent form).*

TO: Social Security Administration

***My Full Name**	***My Date of Birth (MM/DD/YYYY)**	***My Social Security Number**

I authorize the Social Security Administration to release information or records about me to:

***NAME OF PERSON OR ORGANIZATION:** ***ADDRESS OF PERSON OR ORGANIZATION:**

***I want this information released because:** _____

We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**

Check at least one box. We will not disclose records unless you include date ranges where applicable.

1. ☐ Verification of Social Security Number
2. ☐ Current monthly Social Security benefit amount
3. ☐ Current monthly Supplemental Security Income payment amount
4. ☐ My benefit or payment amounts from date_____to date _____
5. ☐ My Medicare entitlement from date_____to date _____
6. ☐ Medical records from my claims folder(s) from date_____to date_____

If you want us to release a minor child's medical records, do not use this form. Instead, contact your local SocialSecurity office.

7. ☐ Complete medical records from my claims folder(s)
8. ☐ Other record(s) from my file (We will not honor a request for "any and all records" or "the entire file." You must specify other

records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** _____ ***Date:** _____

****Address:** _____ ****Daytime Phone:**_____

Relationship (if not the subject of the record): _____ ****Daytime Phone:**_____

Witnesses must sign this form ONLY if the above signature is by mark **(X).** If signed by mark **(X),** two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1. Signature of witness	2. Signature of witness
Address(Number and street ,City, State, and Zip Code)	Address(Number and street, City, State, and Zip Code)

Form **4506**

(November 2020)

Department of the Treasury
Internal Revenue Service

Request for Copy of Tax Return

▸ **Do not sign this form unless all applicable lines have been completed.**
▸ **Request may be rejected if the form is incomplete or illegible.**
▸ **For more information about Form 4506, visit *www.irs.gov/form4506*.**

OMB No. 1545-0429

Tip. You may be able to get your tax return or return information from other sources. If you had your tax return completed by a paid preparer, they should be able to provide you a copy of the return. The IRS can provide a **Tax Return Transcript** for many returns free of charge. The transcript provides most of the line entries from the original tax return and usually contains the information that a third party (such as a mortgage company) requires. See **Form 4506-T, Request for Transcript of Tax Return,** or you can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." or call 1-800-908-9946.

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.

Caution: If the tax return is being sent to the third party, ensure that lines 5 through 7 are completed before signing. (see instructions).

6 **Tax return requested.** Form 1040, 1120, 941, etc. and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ▸

Note: If the copies must be certified for court or administrative proceedings, check here . . . . . ☐

7 **Year or period requested**. Enter the ending date of the tax year or period using the mm/dd/yyyy format (see instructions).

__/__/____ ____ ____ ____ ____ ____ ____ ____

__/__/____ ____ ____ ____ ____ ____ ____ ____

8	**Fee.** There is a $43 fee for each return requested. **Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN, ITIN, or EIN and "Form 4506 request" on your check or money order.**	
a	Cost for each return	$ **43.00**
bc	Number of returns requested on line 7	
	Total cost. Multiply line 8a by line 8b	$

9 If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here . . . . . ☐

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

☐ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506.** See instructions.

Phone number of taxpayer on line1a or 2a

Sign Here

▸ **Signature** (see instructions) | Date

▸ Print/Type name | **Title** (if line 1a above is a corporation, partnership, estate, or trust)

▸ **Spouse's signature** | Date

▸ Print/Type name

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about Form 4506 and its instructions, go to *www.irs.gov/form4506.*

General Instructions

Caution: Do not sign this form unless all applicable lines, *including lines 5 through 7*, have been completed.

Designated Recipient Notification. Internal Revenue Code, Section 6103(c), limits disclosure and use of return information received pursuant tothe taxpayer's consent and holds the recipient subject to penalties for any unauthorized access, other use, or redisclosure without the taxpayer's express permission or request.

Taxpayer Notification. Internal Revenue Code, Section 6103(c), limits disclosure and use of return information provided pursuant to your consent and holds the recipient subject to penalties, brought by private right of action, for any unauthorized access, other use, or redisclosure without your express permission or request.

Purpose of form. Use Form 4506 to request a copyof your tax return. You can also designate (on line 5)a third party to receive the tax return.

How long will it take? It may take up to 75 calendar days for us to process your request.

Where to file. Attach payment and mail Form 4506 to the address below for the state you lived in, or the state your business was in, when that return was filed. There are two address charts: one for individual returns (Form 1040 series) and one for all other returns.

If you are requesting a return for more than one year or period and the chart below shows two different addresses, send your request based on theaddress of your most recent return.

Chart for individual returns (Form 1040 series)

If you filed an individual return and lived in:	Mail to:
Florida, Louisiana, Mississippi, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team Stop 6716 AUSC Austin, TX 73301
Alabama, Arkansas, Delaware, Georgia, Illinois, Indiana, Iowa, Kentucky, Maine, Massachusetts, Minnesota, Missouri, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, South Carolina, Tennessee, Vermont, Virginia, Wisconsin	Internal Revenue Service RAIVS Team Stop 6705 S-2 Kansas City, MO 64999
Alaska, Arizona, California, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Kansas, Maryland, Michigan, Montana, Nebraska, Nevada, New Mexico, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Utah, Washington, West Virginia, Wyoming	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409

Chart for all other returns

For returns not in Form 1040 series, if the address on the return was in:	Mail to:
Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia, Wisconsin	Internal Revenue Service RAIVS Team Stop 6705 S-2 Kansas City, MO 64999
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409

Specific Instructions

Line 1b. Enter the social security number (SSN) or individual taxpayer identification number (ITIN) for the individual listed on line 1a, or enter the employer identification number (EIN) for the business listed on line 1a. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

Line 3. Enter your current address. If you use a P.O. box, please include it on this line 3.

Line 4. Enter the address shown on the last returnfiled if different from the address entered on line 3.

Note. If the addresses on lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address, or Form 8822-B,Change of Address or Responsible Party — Business, with Form 4506.

Line 7. Enter the end date of the tax year or period requested in mm/dd/yyyy format. This may be a calendar year, fiscal year or quarter. Enter each quarter requested for quarterly returns. Example: Enter 12/31/2018 for a calendar year 2018 Form 1040 return, or 03/31/2017 for a first quarter Form 941 return.

Signature and date. Form 4506 must be signed and dated by the taxpayer listed on line 1a or 2a. The IRS must receive Form 4506 within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines, *including lines 5 through 7*, are completed before signing.

You must check the box in the signature area to acknowledge you have the authority to sign and request the information. The form will not be processed and returned to you if the box is unchecked.

Individuals. Copies of jointly filed tax returns maybe furnished to either spouse. Only one signature is required. Sign Form 4506 exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Corporations. Generally, Form 4506 can be signed by: (1) an officer having legal authority to bindthe corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer. A bona fide shareholder of record owning 1 percent or more of the outstanding stock of the corporation may submit a Form 4506 but mustprovide documentation to support the requester's right to receive the information.

Partnerships. Generally, Form 4506 can be signed by any person who was a member of thepartnership during any part of the tax period requested on line 7.

All others. See section 6103(e) if the taxpayer has died, is insolvent, is a dissolved corporation, or if a trustee, guardian, executor, receiver, or administrator is acting for the taxpayer.

Note: If you are Heir at law, Next of kin, or Beneficiary you must be able to establish a materialinterest in the estate or trust.

Documentation. For entities other than individuals, you must attach the authorization document. For example, this could be the letter from the principal officer authorizing an employee of the corporation or the letters testamentary authorizing an individual to act for an estate.

Signature by a representative. A representativecan sign Form 4506 for a taxpayer only if this authority has been specifically delegated to the representative on Form 2848, line 5a. Form 2848 showing the delegation must be attached to Form4506.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to establish your right to gain access to the requested return(s) under the Internal Revenue Code. We needthis information to properly identify the return(s) and respond to your request. If you request a copy of a tax return, sections 6103 and 6109 require you to provide this information, including your SSN or EIN,to process your request. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it tothe Department of Justice for civil and criminal litigation, and cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under atax treaty, to federal and state agencies to enforcefederal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506 will vary depending on individual circumstances. The estimated average time is: **Learning about the law or the form,** 10 min.; **Preparing the form,** 16 min.; and **Copying, assembling, and sending the form to the IRS,** 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506 simpler, we would be happy to hear fromyou. You can write to:

Internal Revenue Service
Tax Forms and Publications Division
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224.

Do not send the form to this address. Instead, see *Where to file* on this page.